Carpenters Local No. 491
Health & Welfare Fund

Board of Trustees Meeting

June 18, 2024

CARPENTERS LOCAL NO. 491
HEALTH AND WELFARE FUND
AGENDA
JUNE 18, 2024

A. ROLL CALL

B. MINUTES OF THE MARCH 20, 2024 BOARD MEETING

C. ADMINISTRATIVE REPORTS

1. Statement of Changes In Fund Balance (Jan - Mar, 2024)
2. Statement of Fund Balance (March 31, 2024)
3. Contribution / Claim Schedules (Jan - Mar, 2024)
4. Claim Payment Schedule (Jan - Mar, 2024)
5. Highest Cost Medical Claims (Jan - Mar, 2024)
6. Bills to be Approved and Paid (June 18, 2024)
7. Cash Management Statement

D. UNFINISHED BUSINESS

1. Delinquent Employer Listing
2. Payroll Audits

E. NEW BUSINESS

1. Bolton Partners Financial Update
2. Bolton Investment Report
3. Express Scripts Rebates
4. PCORI Fees
5. Independence Administrators DOL Subpoena
6. Mental Health Parity Memo
7. Draft Twenty-First Amendment to the Plan
8. ChangeHealthcare Cyberattack
9. Amendment to Administrative Services Agreement
10. Denied Appeal - Prolia - Medical Necessity Review?
11. Questions
12. Date of Next Meeting - September 18, 2024

F. VACATION BENEFIT REPORT

CARPENTERS LOCAL NO. 491
HEALTH AND WELFARE PLAN
REGULAR MEETING OF THE BOARD OF TRUSTEES

March 20, 2024

MINUTES

A regular meeting of the Trustees of the Carpenters Local No. 491 Health and Welfare Plan was held at 10:36 a.m. on March 20, 2024, at the office of the Administrative Manager, Associated Administrators, LLC, 911 Ridgebrook Road, Sparks, Maryland 21152. Present were the following Trustees:

UNION TRUSTEES	EMPLOYER TRUSTEES
Ray Brugueras	Stephen deLeon
Bill Sproule	Mike Joyce
Robert Tarby	Todd Weitzman

Also present were Brad Parsons, Esq., Counsel for the Union; David J. Jensen and Kathy Phillips, Administrative Manager; Ira Marc Miller, CPA; Alton Fryer and Giovanni Forte, of Bolton Partners Investment Consulting Group, Inc.; Pete Tonia; Ryan Devlin, of Bolton Partners, Inc., and Steven I. Batoff, Attorney. Mr. Batoff and the Trustees welcomed Ray Brugueras as a new union trustee.

The following matters were discussed with the indicated action taken:

1. The minutes of the meeting of December 20, 2023, were approved as read after a motion was made by Mr. Tarby and seconded by Mr. deLeon.

2. The Administrative Manager reviewed with the Trustees the Administrative Manager's report for the twelve months ending December 31, 2023. The Fund balance as of December 31, 2023, was $7,902,214.65. The Administrative Manager reviewed with the Trustees the Fund balance report at market value as of December 31, 2023.

The Administrative Manager then reviewed the claims payments for the December 2023 quarter and compared them to the March 2023, June 2023, and September 2023 quarters. The Administrative Manager reported that there was one life insurance claim for the quarter ending December 31, 2023. The Administrative Manager reviewed the highest claim payments for the quarter. Upon motion duly made by Mr. Tarby and seconded by Mr. deLeon, the Administrative Manager's report was unanimously approved by the Trustees.

3. The Administrative Manager then reviewed with the Trustees the bills to be paid, as listed in an attachment to these minutes. The Trustees, upon motion duly made by Mr. deLeon and seconded by Mr. Brugueras, unanimously approved payment of the aforementioned checks.

4. The following Delinquent Contractor Listing was reviewed by the Trustees and the Administrative Manager:

   NONE

5. The Administrative Manager reviewed with the Trustees the cash management statement.

6. Mr. Devlin, of Bolton Partners, Inc., then reviewed with the Trustees the consultant's report for the twelve months ended December 31, 2023. He reviewed the projected annual income for 2023 and the projected annual expenses for 2023. Mr. Devlin stated that the projected annual operating gain for 2023 would be $1,514,726. He then estimated the months in net assets (in reserves) being 22.0 months.

   Mr. Devlin then stated that in preparation for the next meeting of the Trustees, he will consider Page 10 of the Express Scripts report related to injectable and GLP-1 coverage.

7. Alton Fryer and Giovanni Forte, of Bolton Partners Investment Consulting Group, Inc., then reviewed the quarterly review of the Fund as of December 31, 2023. Mr. Fryer then provided a review of the economy and capital markets. He then reviewed asset allocation; asset reconciliation; long term asset growth; portfolio targets; historical performance; calendar year performance; and 3-year risk/reward summary, 5-year risk/reward summary, and 10-year risk/reward summary. He then reviewed calendar year-to-date returns for various investments and their respective benchmark. Mr. Fryer then reviewed the asset allocation as of March 18, 2024.

Mr. Fryer stated that there were no recommended changes to investment managers and reviewed plan notes and the watch list. Western Asset Core Plus remains on the watchlist. Bolton Investment Consulting Group's research team is looking at other fixed-income managers. Mr. Fryer specifically discussed EuroPacific Growth and Dodge & Cox, noting that Bolton has a positive view of these managers.

Mr. Fryer also discussed with the Trustees asset allocation for the Plan. He first reviewed the asset allocation process. He then discussed the asset allocation objectives and modeled portfolios. He then reviewed portfolio statistics and observations.

Mr. Fryer is still on hold as to private real estate.

Mr. Fryer and Mr. Forte then discussed alternative assets/private assets. Mr. Fryer noted that if alternative assets are added to the portfolio, there would probably be a need to change the investment policy statement.

Upon motion duly made by Mr. Weitzman and seconded by Mr. Tarby, the Trustees unanimously approved Mr. Fryer's report.

8. Mr. Batoff reviewed with the Trustees a letter sent by Alina Pargamanik, a lawyer of his firm, dated February 6, 2024, that was emailed to David Jensen, Kathy Phillips, and the Trustees. This letter related to proposed rules issued by the US Department of Labor, US Health and Human Services, and the US Treasury regarding the Mental Health Parity and Addiction Equity Act. The proposed rules are set to be finalized in mid- to late-2024 and are intended to prevent health plans from imposing plan restrictions on mental health and substance use coverage compared to medical and surgical benefits. Mr. Batoff will prepare a draft amendment to the Plan relating to the proposed rules. This amendment will be sent to the Administrative Manager to be added to the agenda for the June 2024 meeting of the Trustees.

9. Dave Jensen then gave a verbal report to the Trustees as to demographics of claims. Mr. Jensen also provided a written report as to demographics of claims.

10. Pete Tonia and Ira Miller reported that there were no payroll audit updates.

11. Chris Kelley, of Express Scripts, Inc., then presented to the Trustees a strategic planning and review consultation. He first reviewed how the Plan compares to its peers. He then reviewed the Plan performance comparing 2022 and 2023. Mr. Kelley then reviewed top line performance metrics and key statistics. Mr. Kelley reviewed the top 25 drugs by plan cost. He then discussed client program savings and impact. Mr. Kelley provided a coverage analysis of injectable and GLP-1 drugs.

12. The Administrative Manager then reviewed the Express Scripts rebates.

13. The Administrative Manager then discussed with the Trustees the renewal of the fiduciary liability insurance policy. The Administrative Manager reported that the

premium is $21,238. The Trustees, upon motion duly made by Mr. Tarby and seconded by Mr. deLeon, unanimously agreed to renew the policy.

14. Mr. Batoff then reviewed with the Trustees the annual gift policy disclosure form, which was executed by all the Trustees.

15. Mr. Batoff then reviewed with the Trustees the conflict of interest policy form, which was executed by all the Trustees.

16. Mr. Batoff reported that the US Department of Labor approved final amendments to the exemption procedures for prohibited transactions under Section 408(a) on January 24, 2024.

17. Mr. Batoff then reviewed with the Trustees his firm's hourly rate. Mr. Batoff stated that his firm's hourly rate for 2024 for the Fund is $365. Mr. Batoff then reviewed his firm's engagement letter, dated June 6, 2016. Mr. Batoff reviewed the letter, which stated that his firm could increase the hourly rate charged the Fund by $10 per hour per year. The engagement letter provides, in relevant part, "Our firm charges at the rate of $325 per hour for services rendered in 2016. These rates may increase from time to time, but no more than $10 per hour per twelve-month period." Mr. Batoff further noted that the average increase since the date of the engagement letter has been $5 per hour per year. The Trustees, upon motion duly made by Mr. deLeon and seconded by Mr. Joyce, unanimously ratified an annual increase in Mr. Batoff's hourly rate per the June 6, 2016, engagement letter for the next three years, but if the increase is to be more than $10 per hour per the engagement letter, Mr. Batoff would need Trustee approval.

18. The Administrative Manager reviewed with the Trustees a participant's appeal of the denial of claims for services provided to her by Corsica Family Chiropractic. The

Administrative Manager, as requested by the Trustees at the December 2023 meeting, contacted Independence Administrators. The Trustees decided to further table this appeal until more information is provided to the Administrative Manager by Independence Administrators or Level Care.

19. Mr. Batoff then reviewed with the Trustees a United States District Court for the District of New Jersey class action lawsuit against Johnson & Johnson by participants enrolled in their employee welfare benefit plans. The plaintiffs alleged that Johnson & Johnson benefits committee breached their fiduciary duties to participants.

20. The Trustees then reviewed with the Administrative Manager the cash balance report for the vacation benefit for the twelve months ending December 31, 2023. The cash balance as of December 31, 2023, was $217,078.88. The Administrative Manager reported that Hargrove did not make contributions for the vacation benefit timely and inquired about a special payment of those late contributions to the members. Upon motion duly made by Mr. deLeon and seconded by Mr. Brugueras, the Trustees unanimously agreed to have a special payout of the Hargrove contributions to eligible members.

There being no further business, the meeting was thereupon adjourned at 12:12 p.m. with the next regular meeting scheduled for June 18, 2024, at 9:00 a.m.

Respectfully submitted,

Steven I. Batoff

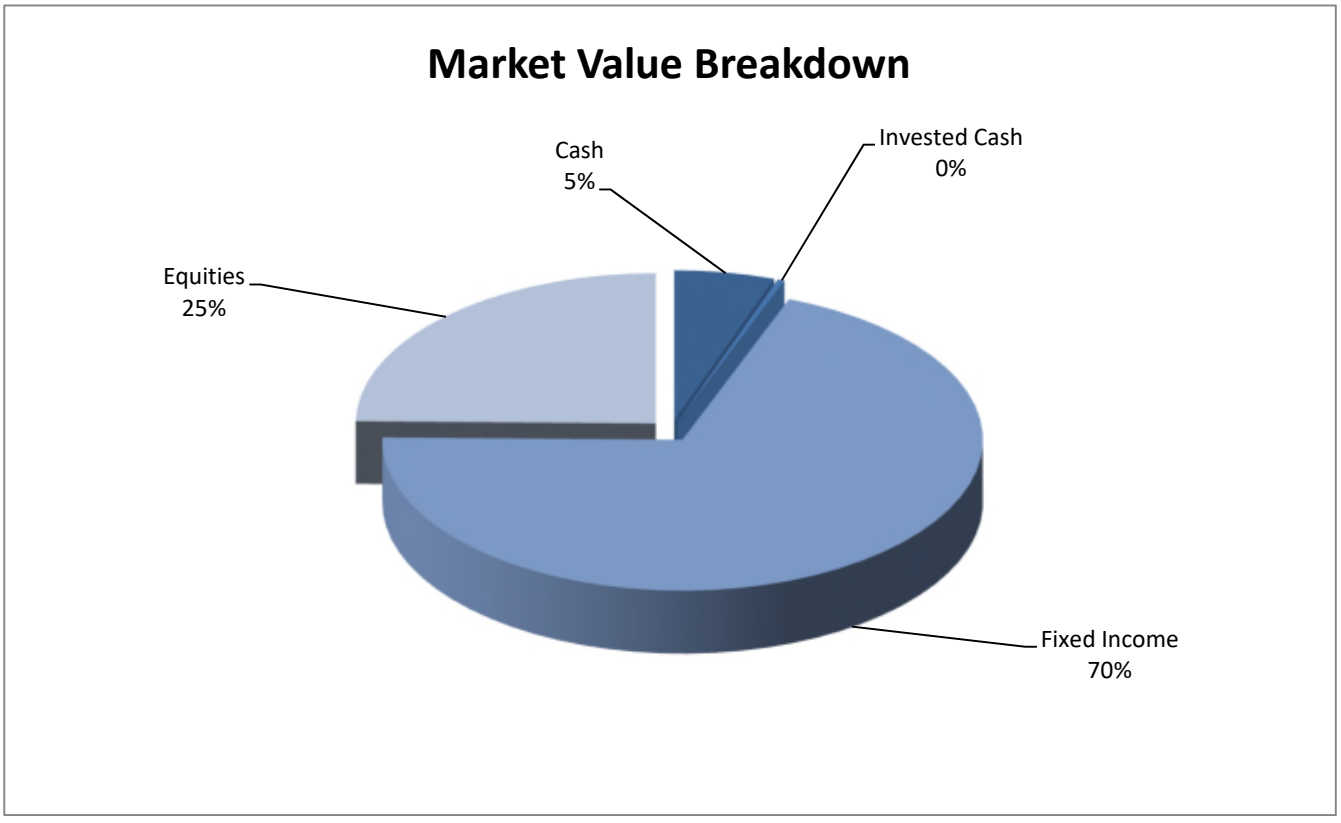
Steven I. Batoff
Secretary of the Meeting

CARPENTERS LOCAL NO. 491 HEALTH AND WELFARE FUND
STATEMENT OF CHANGES IN FUND BALANCE - CASH BASIS
FOR THE THREE MONTHS ENDED MARCH 31, 2024

	Current Quarter	Year To Date
Additions		
Employer/Employee Contributions	$ 697,400.74	$ 697,400.74
Dividends	54,253.85	54,253.85
Interest	378.90	378.90
Rebates / ARPA REFUND	-	-
Gain (Loss) on Sale of Investments	-	-
Securities Litigation Proceeds/Unclaimed Prop.	-	-
Total Additions	752,033.49	752,033.49
Deductions		
Medical Deductions	117,400.41	117,400.41
P.P.O. Fees	-	-
Dental Premium	3,254.40	3,254.40
Claims - IHA	574,886.93	574,886.93
Cobra Reimbursement	-	-
PCORI Fee	-	-
ESI-FWA Fee	-	-
Actuarial Fees	5,000.00	5,000.00
Administration - AA LLC	34,814.00	34,814.00
Administration - IHA	37,141.60	37,141.60
HIPPA Compliance Fees	-	-
Computer Expenses	-	-
Conference Expenses	-	-
Reciprocals Paid	26,759.75	26,759.75
Audit Fees	-	-
Investment Manager Fees	500.00	500.00
Investment Performance Fees	720.00	720.00
Meeting Expense	197.29	197.29
Medical Consultant Fees	-	-
Dues	-	-
Employer Audits	-	-
Fidelity Bond	449.00	449.00
Cyber Liability Insurance	-	-
Fiduciary Liability Insurance	-	-
Independent Fiduciary Fee	58.89	58.89
Stop Loss Insurance	67,964.02	67,964.02
Stop Loss Reimbursement	-	-
Pharmacy Consulting	431.59	431.59
Office Expenses	-	-
Postage	1,344.84	1,344.84
Legal Fees	9,406.90	9,406.90
Printing	126.06	126.06
Hospital Reviews	-	-
Hospital Audits	-	-
Trustee Fees	-	-
Consulting Fees	-	-
Bank Service Charges	2,652.16	2,652.16
Transitional Reinsurance Fee	-	-
Settlement	-	-
Total Deductions	883,107.84	883,107.84
Net Increase (Decrease)	$ (131,074.35)	$ (131,074.35)
Fund Balance - December 31, 2023		7,902,214.65
Fund Balance - March 31, 2024		$ 7,771,140.30

CARPENTERS LOCAL NO. 491 HEALTH AND WELFARE FUND
STATEMENT OF FUND BALANCE
AS OF MARCH 31, 2024

	Cost Basis	Market Basis
PNC Bank		
Cash - Operating	$ 422,502.18	$ 422,502.18
Cash - Benefit	1,128.72	$ 1,128.72
	423,630.90	423,630.90
Amalgamated Bank of Chicago		
Cash & Cash Equivalents	-	-
Money Market	28,981.63	28,981.63
Fixed Income	5,951,510.63	5,439,540.16
Equities	1,360,096.34	1,939,412.89
	7,340,588.60	7,407,934.68
Other Assets & Payables (Net)	6.52	6.52
Independent Health Deposit	61,000.00	61,000.00
Claims Stale Dated	(54,085.72)	(54,085.72)
	$ 7,771,140.30	$ 7,838,486.38
Market Value of Fund Balance as of December 31, 2023		7,898,544.39
Change in Market Value of Fund as of December 31, 2024		$ (60,058.01)
Decrease in Cash		(131,074.35)
Unrealized Gain on Investments		71,016.34
		$ (60,058.01)



CARPENTERS LOCAL NO. 491 HEALTH AND WELFARE FUND
CONTRIBUTIONS / CLAIMS SCHEDULES
FOR THE THREE MONTHS ENDED MARCH 31, 2024

Employer Contributions

Hourly rates and their effective dates

Date	Shops	Exhibitors
03/01/07	2.40	3.55
07/17/07	2.50	3.55
01/17/08	2.60	3.55
03/01/08	2.60	3.80
07/17/08	2.70	3.80
01/17/09	2.80	3.80
03/01/09	2.80	4.15
03/01/10	2.80	4.45
03/01/11	2.80	4.60
07/17/11	3.00	4.60
03/01/12	3.00	5.00
03/01/13	3.00	5.25
03/01/14	3.15	5.60
07/01/14	3.40	5.60
03/01/15	3.40	5.85
07/20/15	3.50	5.85
03/01/14	3.50	6.10
05/01/21	3.50	6.35
05/01/23	3.50	6.45

Employer / Employee

Prior Years Analysis

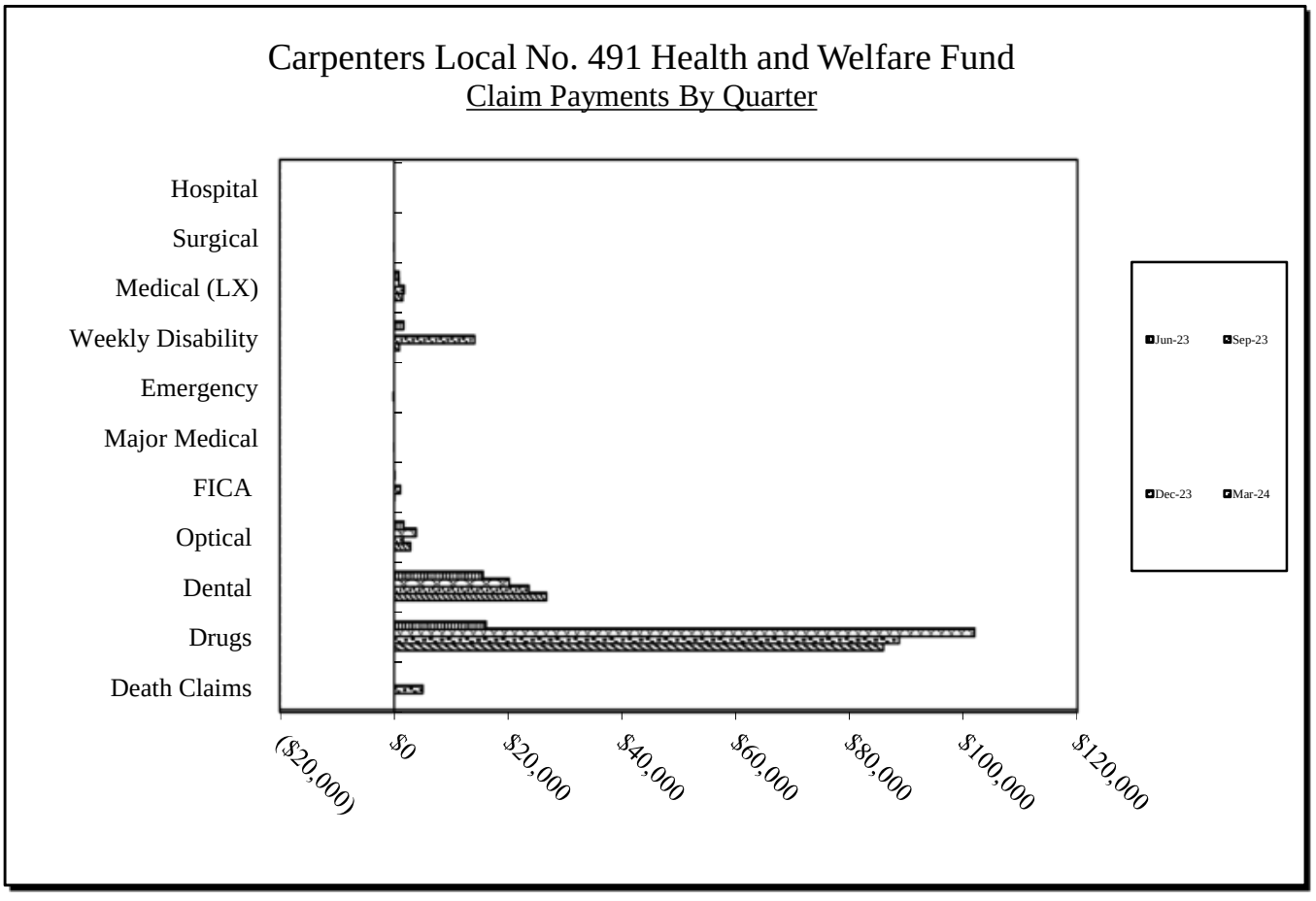
Year	Receipts	Claims	Difference
2014	$ 4,262,555.33	$ 3,252,072.12	$ 1,010,483.21
2015	4,501,646.07	2,728,405.47	1,773,240.60
2016	4,881,298.31	2,918,759.70	1,962,538.61
2017	5,049,927.78	2,915,661.88	2,134,265.90
2018	4,793,825.81	3,650,944.24	1,142,881.57
2019	4,818,837.41	4,379,457.69	439,379.72
2020	1,468,255.49	3,799,144.27	(2,330,888.78)
2021	1,415,440.80	3,022,642.31	(1,607,201.51)
2022	3,777,970.93	2,655,341.73	1,122,629.20
2023	4,323,685.84	2,684,211.32	1,639,474.52
2024	697,400.74	692,287.34	5,113.40

Current Year Analysis

Month	Receipts	Claims	Difference
January	$ 169,561.49	$ 148,827.99	$ 20,733.50
February	$ 232,742.93	$ 301,000.41	(68,257.48)
March	$ 295,096.32	$ 242,458.94	52,637.38
April			-
May			-
June			-
July			-
August			-
September			-
October			-
November			-
December			-
	$ 697,400.74	$ 692,287.34	$ 5,113.40
Average Per Month	$ 232,466.91	$ 230,762.45	$ 426.12

CARPENTERS LOCAL NO. 491 HEALTH AND WELFARE FUND
CLAIM PAYMENT SCHEDULE
FOR THE THREE MONTHS ENDED MARCH 31, 2024

Claim Payments	**Jun-23 Quarter**	**Sep-23 Quarter**	**Dec-23 Quarter**	**Mar-24 Quarter**
Hospital	$ -	$ -	$ -	$ -
Surgical	-	-	-	(40.26)
Medical (LX)	812.62	860.21	1,731.66	1,493.80
Weekly Disability	1,671.44	-	14,057.18	900.00
Emergency	-	-	-	(133.51)
Major Medical	-	-	-	(28.00)
FICA	127.87	-	1,075.38	68.85
	2,611.93	860.21	16,864.22	2,260.88
Optical	1,677.56	3,856.55	1,577.14	2,874.68
Dental	15,548.18	20,128.78	23,551.67	26,665.47
Drugs	16,061.65	101,730.12	88,356.55	85,599.38
	33,287.39	125,715.45	113,485.36	115,139.53
Death Claims	-	-	5,000.00	-
	$ 35,899.32	$ 126,575.66	$ 135,349.58	$ 117,400.41
IHA Claims	641,058.84	561,392.12	570,239.68	574,886.93
	$ 676,958.16	$ 687,967.78	$ 705,589.26	$ 692,287.34



High Cost Members

Population: Carpenters Local No. 491 Health and Welfare Plan

Reporting Period: Paid January 1, 2024 to March 31, 2024

Threshold: $50,000 **Amount: Paid** **Total Members: 3**

SN	Rel Class	Gender	Age	Eligibility As of 03/31/24	Highest Paid Diagnosis	Medical Paid Amount	Pharmacy Paid Amount	Total Paid Amount
1	Employee	Male	39	Active	Mental Health	$83,710.68	$335.18	$84,045.86
2	Employee	Male	63	Active	Cancer	$57,335.88	$16,631.22	$73,967.10
3	Spouse	Female	59	Active	Neurological Disorders	$60,207.45	$1,504.04	$61,711.49
Total						$201,254.01	$18,470.44	$219,724.45

CARPENTERS LOCAL NO. 491 HEALTH AND WELFARE FUND
BILLS TO BE APPROVED AND PAID
OPERATING ACCOUNT
June 18, 2024

Payee/Purpose	Period	Check #	Amount
1. Batoff Associates, P.A.			
Legal Fees	2/24	1271	2,118.20
2. CIGNA Dental Health, Inc.			
Dental Premium	3/24	1272	1,082.88
3. Union Labor Life Insurance Company			
Stop Loss Premium	3/24	1273	22,774.63
4. Bolton Partners, Inc.			
Investment Performance Fee	11/23 - 01/24	1274	720.00
5. Bolton Partners, Inc.			
Actuarial Retainer	1/24 - 3/24	1275	5,000.00
6. The Wagner Law Group			
Fiduciary Fee	1/24	1276	18.22
7. Associated Administrators, LLC			
Postage-$261.45-Printing-$126.06 - Telehealth Notice	2/24	1277	387.51
8. Washington Area Carpenters' Fund			
Reciprocal Hours	1/24	1278	7,100.02
9. Associated Administrators, LLC			
Administration Fee	4/24 - 6/24	1279	36,207.00
10. Batoff Associates, P.A.			
Legal Fees	3/24	1280	2,956.50
11. York Insurance Services, Inc.			
Fiduciary Liability Insurance	3/24 - 3/25	1281	5,495.67
12. CIGNA Dental Health, Inc.			
Dental Premium	4/24	1282	1,016.64
13. The Wagner Law Group			
Fiduciary Fee	2/24	1283	18.42
14. Union Labor Life Insurance Company			
Stop Loss Premium	4/24	1284	23,494.37
15. Washington Area Carpenters' Fund			
Reciprocal Hours	2/24	1285	6,143.65
16. Associated Administrators, LLC			
Meeting Expense	3/24	1286	205.58
17. Schmitz Press, Inc.			

CARPENTERS LOCAL NO. 491 HEALTH AND WELFARE FUND
BILLS TO BE APPROVED AND PAID
OPERATING ACCOUNT
June 18, 2024

Payee/Purpose	Period	Check #	Amount
Postage - QSR's	4/24	1287	513.92
18. Batoff Associates, P.A.			
Legal Fees	4/24	1288	4,015.00
19. CIGNA Dental Health, Inc.			
Dental Premium	5/24	1289	1,160.64
20. Schmitz Press, Inc.			
Postage - QSR's	4/24	1290	109.71
21. Union Labor Life Insurance Company			
Stop Loss Premium	5/24	1291	24,059.88
22. The Wagner Law Group			
Fiduciary Fee	3/24	1292	22.82
			$ 144,621.26

Carpenters Local 491 Benefit Funds
Cash Management

		Medical
Yearly Deductions		$ 3,519,142
Loans per Year		
Total Yearly Deductions		
10% of Expenses		$ 351,914
Current Cash Balance	As of 4/30/24	$ 480,459
5% Floor		$ 175,957
Replenish		Not now
15% Ceiling		$ 527,871
Send to Amalgamated		**Not now**
Transfer Made:	Jun-12-24	$ -

CARPENTERS DELINQUENCY LIST
AS OF
JUNE 14, 2024

1) If Local has "X" in a block, please indicate "Worked" or "No Men"
2) Please fax updates to Ramona at 410-683-7794

	See Instructions Above			
EMP #	**Balt.**	**Wash.**	**COMPANY NAME**	**WORK MONTHS DELINQ.**

LOCAL 491 AUDIT UPDATE

STATUS	EMPLOYER NAME	AUDIT DATE(S)	AUDIT AMOUNT	LIQUIDATED DAMAGES	AUDIT FEE	TOTAL DUE	COMMENTS	HOURS	AUDIT YEAR
IN PROGRESS	ATLANTIC EXPO	5/16/2024	$0.00	$0.00	$0.00	$0.00		0	01/01/2021-12/31/2023
IN PROGRESS	CZARNOWSKI DISPLAY	6/14/2024	$0.00	$0.00	$0.00	$0.00		0	01/01/2020-12/31/2023
IN PROGRESS	DONALD E MCNABB	1/31/2024	$0.00	$0.00	$0.00	$0.00		0	01/01/2018-12/31/2022
IN PROGRESS	GENERAL EXPOSITIONS SERV	2/12/2024	$0.00	$0.00	$0.00	$0.00		0	01/01/2021-12/31/2023
IN PROGRESS	HARGROVE INC.	6/3/2024	$0.00	$0.00	$0.00	$0.00		0	01/01/2018-12/31/2022
IN PROGRESS	NTH DEGREE	2/23/2024	$0.00	$0.00	$0.00	$0.00		0	09/01/2021-12/31/2023
IN PROGRESS	SPECTRUM SHOW SERVICES INC.	1/18/2024	$0.00	$0.00	$0.00	$0.00		0	01/01/2018-12/31/2022
SCHEDULED	MOMENTUM MANAGEMENT	6/24/2024	$0.00	$0.00	$0.00	$0.00		0	01/01/2019-12/31/2023
SCHEDULED	SHEPARD EXPOSITION SERVICES	7/22/2024	$0.00	$0.00	$0.00	$0.00		0	01/01/2021-12/31/2023
REQUESTED	ARATA EXPOSITION INC.		$0.00	$0.00	$0.00	$0.00		0	01/01/2020-12/31/2023
REQUESTED	BREDE-WASHINGTON		$0.00	$0.00	$0.00	$0.00		0	01/01/2020-12/31/2023
REQUESTED	BRUNSWICK WOODWORKING CO INC		$0.00	$0.00	$0.00	$0.00		0	07/01/2019-12/31/2023
REQUESTED	BUILDTASK		$0.00	$0.00	$0.00	$0.00		0	01/01/2018-12/31/2023
REQUESTED	COASTAL INTERNATIONAL INC.		$0.00	$0.00	$0.00	$0.00		0	01/01/2020-12/31/2023
REQUESTED	EMPLOYCO		$0.00	$0.00	$0.00	$0.00		0	01/01/2018-12/31/2023
REQUESTED	EXHIBIT WORKS INC.		$0.00	$0.00	$0.00	$0.00		0	01/01/2018-12/31/2023
REQUESTED	FREEMAN EXPOSITION INC.		$0.00	$0.00	$0.00	$0.00		0	01/01/2020-12/31/2022
REQUESTED	LANCASTER MANAGEMENT		$0.00	$0.00	$0.00	$0.00		0	01/01/2018-12/31/2023
REQUESTED	SHO-AIDS		$0.00	$0.00	$0.00	$0.00		0	01/01/2018-12/31/2023
REQUESTED	SMITH AND STILLWELL		$0.00	$0.00	$0.00	$0.00		0	01/01/2018-12/31/2023
REQUESTED	WILLWORK		$0.00	$0.00	$0.00	$0.00		0	07/01/2019-12/31/2023

000427 5725405 01/01

J12650020901

Express Scripts Inc
St. Louis MO 63121

CARPENTERS LOCAL 491 H&W FUND
ATTN: DAWN WELCH
911 RIDGEBROOK ROAD
SPARKS MD 21152

Check Explanation:

Invoice #:	Date:	Description:	Amount:
RD6A R00007004483	03/29/2024	REBATE 12-01-2023-12-31-2023	14022.50

CL28

Express Scripts Inc
St. Louis MO 63121

Fifth Third Bank
Cincinnati, OH
73-27
421

1014818

DATE 29 Mar 2024

PAY *Fourteen thousand twenty two and 50/100 Dollars*

AMOUNT
***$14,022.50

TO THE ORDER OF
CARPENTERS LOCAL 491 H&W FUND
ATTN: DAWN WELCH
911 RIDGEBROOK ROAD
SPARKS MD 21152

VOID AFTER 180 DAYS

Benjamin F Chestnut

THE ORIGINAL DOCUMENT HAS A REFLECTIVE WATERMARK
ON THE BACK. HOLD AT AN ANGLE TO VIEW

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Express Scripts Inc
St. Louis MO 63121

E50820005101

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

CARPENTERS LOCAL 491 H&W FUND
ATTN: DAWN WELCH
911 RIDGEBROOK ROAD
SPARKS, MD 21152

Check Explanation

Invoice #:	Date:	Description:	Amount:
RD6A R00007004483	04/30/2024	REBATE 01-01-2024-01-31-2024	18404.09

Please direct any questions to: 1-877-434-2729

Express Scripts Inc
St. Louis MO 63121

Fifth Third Bank
Cincinnati, OH

73-27
421

0001015184

DATE 01 May 2024

AMOUNT
***$18,404.09**

EXPRESS SCRIPTS®
PAY
EIGHTEEN THOUSAND FOUR HUNDRED FOUR DOLLARS AND 09 CENTS

TO THE ORDER OF
CARPENTERS LOCAL 491 H&W FUND
ATTN: DAWN WELCH
911 RIDGEBROOK ROAD
SPARKS, MD 21152

Benjamin F Chestnut

VOID VOID VOID VOID VOID VOID

SECURITY FEATURES INCLUDED. DETAILS ON BACK.

MP

⑈000101518⑈ ⑆042100272⑆ 187482186397⑈

Express Scripts Inc
St. Louis MO 63121

E51750011201

EXPRESS SCRIPTS®

000191 7612342 01/01

CARPENTERS LOCAL 491 H&W FUND
ATTN: DAWN WELCH
911 RIDGEBROOK ROAD
SPARKS, MD 21152

Check Explanation

Invoice #:	Date:	Description:	Amount:
RD6A R00007004483	05/31/2024	REBATE 02-01-2024-02-29-2024	8616.06

Please direct any questions to: 1-877-434-2729

Express Scripts Inc
St. Louis MO 63121

EXPRESS SCRIPTS®

Fifth Third Bank
Cincinnati, OH

73-27
421

0001015884

DATE 03 Jun 2024

PAY
EIGHT THOUSAND SIX HUNDRED SIXTEEN DOLLARS AND 06 CENTS

AMOUNT
****$8,616.06**

TO THE ORDER OF
CARPENTERS LOCAL 491 H&W FUND
ATTN: DAWN WELCH
911 RIDGEBROOK ROAD
SPARKS, MD 21152

Benjamin F Chestnut

SECURITY FEATURES INCLUDED. DETAILS ON BACK.

MP

⑈0001015884⑈ ⑆042100272⑆ 748218639?⑈

MENTAL HEALTH PARITY

1. Summary of the Current Applicable Laws

The Mental Health Parity Act of 1996 ("**MHPA**") provided that large group health plans[1] cannot impose annual or lifetime dollar limits on mental health benefits that are less favorable than any such limits imposed on medical/surgical benefits. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("**MHPAEA**") is a federal law that preserves the MHPA protections and adds significant new protections, such as extending the parity requirements to substance use disorders.

MHPAEA originally applied to group health plans and group health insurance coverage and was amended by the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the "**Affordable Care Act**") to also apply to individual health insurance coverage. The Department of Health and Human Services ("**HHS**") has jurisdiction over public sector group health plans (referred to as "**non-Federal governmental plans**"), while the Departments of Labor ("**DOL**") and the Treasury Department ("**TD**") (collectively, the "**Departments**") have jurisdiction over private group health plans.

The Consolidated Appropriations Act, 2021 (the "**Appropriations Act**") was enacted on December 27, 2020, and amended MHPAEA to provide important new protections. It expressly requires group health plans and health insurance issuers offering group or individual health insurance coverage that offers both medical/surgical benefits and mental health/substance use disorder ("**MH/SUD**") benefits and that impose non-quantitative treatment limitations ("**NQTLs**") on MH/SUD benefits to perform and document their comparative analyses of the design and application of NQTLs. Further, beginning 45 days after the date of enactment of the Appropriations Act, these plans and issuers must make their comparative analyses available to the Departments or applicable State authorities, upon request.

2. Key changes made by MHPAEA

Key changes made by MHPAEA include the following:

- If a group health plan or health insurance coverage includes medical/surgical benefits and MH/SUD benefits, the financial requirements (e.g., deductibles and co-payments) and treatment limitations (e.g., number of visits or days of coverage) that apply to MH/SUD benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits (this is referred to as the "**substantially all/predominant test**").

[1] MHPAEA does not apply directly to small group health plans, although its requirements are applied indirectly in connection with the Affordable Care Act's essential health benefit ("**EHB**") requirements. The Protecting Affordable Coverage for Employees Act amended the definition of small employer in section 1304(b) of the Affordable Care Act and section 2791(e) of the Public Health Service Act to mean generally an employer with 1-50 employees, with the option for states to expand the definition of small employer to 1-100 employees. The Employee Retirement Income Security Act and the Internal Revenue Code also define a small employer as one that has 50 or fewer employees. Maryland follows the same definition for a small group health plan of 1-50 employees.

- MH/SUD benefits may not be subject to any separate cost-sharing requirements or treatment limitations that only apply to such benefits;
- If a group health plan or health insurance coverage includes medical/surgical benefits and MH/SUD benefits, and the plan or coverage provides for out-of-network medical/surgical benefits, it must provide for out-of-network MH/SUD benefits; and
- Standards for medical necessity determinations and reasons for any denial of benefits relating to MH/SUD benefits must be disclosed upon request.

3. Exceptions to the MHPAEA requirements.

MHPAEA requirements do not apply to:

- Self-insured non-Federal governmental plans that have 50 or fewer employees;
- Self-insured small private employers that have 50 or fewer employees; and
- Group health plans and health insurance issuers that are exempt from MHPAEA based on their increased cost (except as noted below). Plans and issuers that make changes to comply with MHPAEA and incur an increased cost of at least two percent in the first year that MHPAEA applies to the plan or coverage or at least one percent in any subsequent plan year may claim an exemption from MHPAEA based on their increased cost. If such a cost is incurred, the plan or coverage is exempt from MHPAEA requirements for the plan or policy year following the year the cost was incurred. The plan sponsors or issuers must notify the plan beneficiaries that MHPAEA does not apply to their coverage. These exemptions last one year. After that, the plan or coverage is required to comply again; however, if the plan or coverage incurs an increased cost of at least one percent in that plan or policy year, the plan or coverage could claim the exemption for the following plan or policy year.

4. **MHPAEA Regulation**.

A regulation implementing MHPAEA was effective January 13, 2014, and generally applies to plan years beginning on or after July 1, 2014. The final regulation applies to non-Federal governmental plans with more than 50 employees, and to group health plans of private employers with more than 50 employees. Like the MHPA, it does not require group health plans to provide MH/SUD benefits. If they do, however, the financial requirements and treatment limitations that apply to MH/SUD benefits cannot be more restrictive than the predominant requirements and limitations that apply to substantially all of the medical/surgical benefits.

The provisions of the regulation include the following:

- The substantially all/predominant test outlined in the statute must be applied separately to six classifications of benefits: (i) inpatient in-network; (ii) inpatient out-of-network; (iii) outpatient in-network; (iv) outpatient out-of-network; (v) emergency; and (vi) prescription drug. Although the regulation does not require plans to cover MH/SUD benefits, if they do, they must provide MH/SUD benefits in all classifications in which medical/surgical benefits are provided.
- The regulation requires that all cumulative financial requirements, including deductibles and out-of-pocket limits, in a classification must combine both medical/surgical and MH/SUD benefits in the classification.

- The regulation distinguishes between quantitative and nonquantitative treatment limitations. Quantitative treatment limitations are numerical, such as visit limits and day limits. Nonquantitative treatment limitations include medical management, step therapy and pre-authorization. A group health plan or coverage cannot impose a nonquantitative treatment limitation with respect to MH/SUD benefits unless "comparable to, and applied no more stringently than", the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification. The final regulation eliminated an exception that allowed for different nonquantitative treatment limitations "to the extent that recognized clinically appropriate standards of care may permit a difference."
- The regulation provides that all plan standards that limit the scope or duration of benefits for services are subject to the nonquantitative treatment limitation parity requirements. This includes restrictions such as geographic limits, facility-type limits, and network adequacy.

5. **Key Changes made by the Appropriations Act**.

Comparative analysis of the design and application of NQTLs which must be submitted to the Departments or applicable State authorities **upon request** and must include the following information:

- The specific plan or coverage terms regarding the NQTLs and a description of all MH/SUD and medical or surgical benefits to which each such term applies in each respective benefits classification;
- The factors used to determine that the NQTLs will apply to MH/SUD benefits and medical or
  surgical benefits;
- The evidentiary standards used for the factors identified, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and
  apply the NQTLs to MH/SUD benefits and medical or surgical benefits;
- The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical/surgical benefits in the benefits classification; and
- The specific findings and conclusions reached by the plan or issuer, including any results of
  the analyses that indicate that the plan or coverage is or is not in compliance with the MHPAEA requirements.

The Appropriations Act also provides that the Departments can request that a group health plan or issuer submit the comparative analyses for plans that involve potential MHPAEA violations or complaints regarding noncompliance with MHPAEA that concern NQTLs, and any other instances in which the Departments determine appropriate. The Appropriations Act further requires the Departments, after review of the comparative analyses, to share information on findings of compliance and noncompliance with the State where the plan is located or the State where the issuer is licensed to do business.

Under the Appropriations Act, plans and issuers must now be prepared to submit their comparative analysis with respect to each NQTL imposed when requested by any of the Departments or by an applicable State authority. For an analysis to be treated as sufficient under
the Appropriations Act, it must contain a detailed, written, and reasoned explanation of the specific plan terms and practices at issue, and include the bases for the plan's or issuer's conclusion that the NQTLs comply with MHPAEA and should include:

- A clear description of the specific NQTL, plan terms, and policies at issue.
- Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.
- Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.
- To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.
- The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
- If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.
- A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.
- The date of the analyses and the name, title, and position of the person or persons who performed or participated in the comparative analyses.

If the Departments conclude a plan or issuer has not provided sufficient information to review the comparative analyses, the Appropriations Act provides that the Departments must specify to the plan or issuer the information that must be submitted to be responsive to the request.

6. **New Proposed Rule**.

The parity rules continue to evolve. On July 25, 2023, the Departments of Labor and Health and Human Services released a proposed rule intended to strengthen enforcement of the MHPAEA and improve patients' ability to access care for MH/SUD. From a practical standpoint, it will close loopholes in MHPAEA that insurance companies routinely use to deny care for mental health conditions and substance use disorders. If finalized, the new rule is expected to take effect on Jan. 1, 2025, for group health plans and on Jan. 1, 2026, for individual health plans. The proposed rule codifies the requirement, enacted by the Appropriations Act, that insurers perform and document comparative analyses for all NQTLs imposed on MHSUD services[2].

The proposed rule:

- Clarifies that the purpose of MHPAEA is to ensure plan participants can access their MH/SUD benefits in parity with their medical/surgical benefits.
- Requires plan/issuers to provide meaningful MH/SUD benefits. Under the proposed rule, if a plan provides treatment for a specific condition in one benefit classification (e.g., inpatient/in-network, inpatient/out-of-network, outpatient/in-network, outpatient/out-of-network, prescription drugs, and emergency care), it must provide for treatment in all six benefit classifications. For example, if a plan covers treatment for autism (e.g., ABA therapy) on an outpatient/in-network basis, the plan must also provide the autism benefit in the other five benefit classifications.
- Clarifies that **eating disorders and autism spectrum disorder** are considered mental health conditions and protected under MHPAEA.
- Requires plans/issuers to collect, evaluate, and consider the impact of various outcome data (e.g., claim denial rates) and take "reasonable action" to address "material differences" in accessing MH/SUD benefits compared to medical/surgical benefits and document this action in the NQTL comparative analysis. This includes evaluating their actual provider networks, how much they pay out-of-network providers, how often prior authorization is required, and the rate at which prior authorizations are denied. "Material difference" is not defined in the proposal.
- Requires plans to collect and analyze data on the outcomes of their NQTLs and address material differences in access between mental and other medical benefits.
- Requires plans to demonstrate, with a corrective action plan, that they have made necessary changes to ensure compliance with MHPAEA if the analyses show they're failing to meet the parity law's requirements and to document those actions in their comparative analyses.

[2] There are major concerns within the health-care industry that common techniques used to control costs for employee health plans would be eliminated under the proposed rule. The proposal's "substantially all" test says that under the MHPAEA, "non-quantitative treatment limitations" must be applied at similar levels to medical and surgical benefits if they are applied to mental health benefits. Groups representing employer-sponsored health plans have been particularly vocal in pushing back against the proposed rules, arguing they will have to stop using many NQTLs as they would cause plans to fail the new substantially all test. See, https://news.bloomberglaw.com/product/blaw/bloomberglawnews/exp/eyJpZCI6IjAwMDAwMThmLTExMjktZGRhOC1hNzhmLTE3N2QyNjAzMDAwMSIsImN0eHQiOiJFQk5XIiwidXVpZCI6IkJUUkpHL2FpUnh6NGgzM3lMTTloK3c9PWtHNGVPUEE3WEg3a1VFY3c4Wno2SHc9PSIsInRpbWUiOiIxNzE0OTkyODI4MDg3Iiwic2lnIjoiSEFFd092cW5pNEF2R3VYUzNQZlVTR2xBai9jPSIsInYiOiIxIn0=?source=newsletter&item=body-link&region=text-section&channel=employee-benefits

- Provides an exception to the requirements for NQTLs if the plan/issuer "applies a nonquantitative treatment limitation that impartially applies independent professional medical or clinical standards or applies standards to detect or prevent and prove fraud, waste, and abuse."
- Proposes an enforcement safe harbor for plans/issuers that can demonstrate that the material differences in access exist because of provider shortages and despite their reasonable efforts to expand their MH/SUD provider networks.
- Requires NQTL comparative analyses to include a certification by one or more named fiduciaries who have reviewed the analysis, stating they found it to be in compliance with the proposed rule's content requirements.

7. **Next Steps**.

- Review plan documents to ensure parity between MH/SUD benefits and medical/surgical benefits.
- Make sure eating disorders and autism spectrum disorder are considered mental health conditions and are protected under MHPAEA.
- If the plan provides treatment for a specific condition in one benefit classification (e.g., inpatient/in-network, inpatient/out-of-network, outpatient/in-network, outpatient/out-of-network, prescription drugs, and emergency care), it must provide for treatment in all six benefit classifications.
- Collect, evaluate, and consider the impact of various outcome data (e.g., claim denial rates) and take "reasonable action" to address "material differences" in accessing MH/SUD benefits compared to medical/surgical benefits and document this action in the NQTL comparative analysis.
- Collect and analyze data on the outcomes of NQTLs and address material differences in access between mental and other medical benefits.
- Document any corrective action plans for compliance.
- Complete a fiduciary review for compliance.

TWENTY-FIRST AMENDMENT

TO THE

CARPENTERS LOCAL NO. 491 HEALTH AND WELFARE PLAN

Pursuant to the Powers of Amendment reserved under Section 15.1 of Article XV of the Carpenters Local No. 491 Health and Welfare Plan (the "Plan"), as amended and restated, effective as of January 1, 2014, said Plan shall be and is hereby amended by the Trustees of the Carpenters Local No. 491 Health and Welfare Plan (the "Trustees"), effective retroactive to January 1, 2024, as follows:

FIRST AND ONLY CHANGE

As previously amended by the Thirteenth Amendment, Article X shall be deleted in its entirety, and the following language is substituted in lieu thereof:

"**ARTICLE X**

GENERAL LIMITATIONS AND EXCLUSIONS

The following charges are not covered under this Plan; therefore, the amount of benefits payable under the Plan is determined after these charges are deducted from covered expenses:

(a) charges incurred while not covered under this Plan;

(b) charges that would not have been made if coverage did not exist;

(c) charges that an Employee or their Dependents are not required to pay;

(d) charges for services or supplies which are furnished, paid or otherwise provided for by reason of the past or present service of any person in the armed forces unless otherwise required by law;

(e) charges for nursing or other services performed by a person who ordinarily resides in the patient's home or is a member of the Employee's family or the Employee's spouse's family;

(f) charges for services or supplies which are paid for or otherwise provided for under any laws of the government unless required by federal law;

(g) charges for services or supplies which are not medically necessary for treatment of an injury or illness or are not provided, recommended or prescribed by a legally-qualified surgeon or Doctor;

(h) charges to the extent that they are not usual, customary and reasonable;

(i) charges for an injury or illness covered by workers' compensation laws;

(j) charges for the purchase or fitting of a hearing aid;

(k) charges for blood plasma or whole blood;

(l) charges by an intern of a Hospital;

(m) charges for transportation or travel except as otherwise covered under the Plan;

(n) medicines which may be purchased without a prescription or are not prescribed to treat an illness or injury;

(o) charges for custodial care;

(p) charges for or in connection with experimental procedures or treatment methods not approved by the American Medical Association or the appropriate medical specialty society;

(q) charges for telephone consultations, for failure to keep a scheduled visit, for completion of forms, or other non-medical or administrative services;

(r) charges for dependent child maternity benefits outside of those prenatal services that are considered preventative services under the PPACA;

(s) charges for chiropractic care;

(t) charges incurred as a result of war, declared or undeclared, including armed aggression;

(u) charges incurred as the result of a commission of a crime (If a copy of a police report is required, this will be obtained at the expense of the covered individual);

(v) cosmetic procedures (except as otherwise required by law) and associated expenses;

(w) the services of private duty registered and licensed practical nurses, unless medically necessary;

(x) physical or psychiatric examinations or psychological testing for purposes of obtaining or maintaining employment, licensure, legal proceeding, registration or insurance, or conducted for purposes of medical research, physical examinations for camp, school, sport, or other similar activities;

(y) any elective surgical procedure including all associated expenses, intended primarily for treatment of morbid obesity;

(z) any surgical procedure, including all associated health services, for the reversal of voluntary sterilization;

(aa) any loss or charges for sexual transformation, sexual enhancement or any treatment relative to sexual dysfunction, unless medically necessary;

(bb) artificial insemination;

(cc) in-vitro fertilization and embryo transplants;

(dd) charges for services or supplies for the diagnosis or treatment of Temporomandibular Joint Dysfunction (TMJ) and any related disorders or procedures regardless of medical necessity;

(ee) charges incurred or resulting from an injury caused by a third party in which the eligible Employee or covered Dependent has recovered by suit, settlement or otherwise;

(ff) dental X-rays, except in the case of an accidental Bodily Injury;

(gg) examinations that are not recommended or approved by a legally qualified Doctor or surgeon;

(hh) eye examinations, unless otherwise provided in the Plan;

(ii) dental disorders, except as otherwise provided in the Plan;

(jj) eye refraction, eyeglasses or their fitting, except as provided under the Vision Benefits section of the Plan;

(kk) hearing aids or their fittings;

(ll) drugs and medicines, except as otherwise provided herein; or

(mm) charges incurred due to psychiatric or personality disorders, drug abuse or alcohol abuse, except as otherwise required by the Mental Health Parity and Addiction Equity Act.

The term “custodial care” means services and supplies, including room and board and other institutional services, primarily to assist a person in the activities of daily living, whether or not he/she is disabled. However, room and board and skilled nursing care for a person in a Hospital are not considered custodial care if they must be combined with therapeutic services needed to improve his/her medical condition.

The Plan only covers treatments, services or supplies that are necessary, reasonable and recommended or approved by the attending Doctor.”

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, the Trustees have executed this Twenty-First Amendment to the Plan this _____ day of _____, 2024.

_____
RAY BRUGUERAS

_____
STEPHEN DELEON

_____
WILLIAM SPROULE

_____
MIKE JOYCE

_____
ROBERT TARBY

_____
TODD WEITZMAN

UnitedHealth Group – Change Healthcare Cyberattack
Announcement to Potentially Impacted Individuals

On February 21, 2024, Change Healthcare ("CHC"), a vendor of Associated Administrators, LLC, experienced a cyberattack and immediately took steps to stop the activity and investigate the extent of the attack. CHC engaged cybersecurity experts and law enforcement to assist in the investigation.

CHC provides services to the Health and Welfare Plan in which you participate, including processing and mailing Explanation of Benefits letters and mailing claims payments. To fulfill these services, your personal data is shared with CHC.

In light of the recent CHC cyberattack, United Health Group ("UHG"), the parent company of CHC, recently announced that their initial analysis of affected data shows that a substantial proportion of the American population may have been affected by this cyberattack. Given the ongoing complexity of the data review, it will likely be several months before UHG will be able to identify which individuals and data were affected.

UHG states that they understand the concern this cyberattack has caused potentially affected individuals, and while they are not able to confirm a breach of any one individual's information, UHG is offering two years of free credit monitoring and identity protection services to any individual who is concerned that they may been affected by this cyberattack.

If you would like to take advantage of UHG's free credit monitoring and identity protection services, you can contact UHG's dedicated call center at **1-866-262-5342** to opt-in. The call center cannot provide any specifics on whether any individual's data has been impacted. Additional details, including UHG's recommendations for safeguarding your information, can be found on their website at:

http://changecybersupport.com/

June 2024

RE: Change Healthcare Cyberattack Update

Dear Board of Trustees:

We are providing you with an update regarding the Change Healthcare ("CHC") cyberattack as it relates to potentially affected individuals.

United Health Group ("UHG"), CHC's parent company, announced that their initial data analysis shows a likelihood that a substantial proportion of the American population may have been affected by the cyberattack. Given the ongoing complexity of the data review, it will likely take several months of continued analysis before they can identify which clients, individuals and data were impacted.

Although UHG reaffirms that this is not an official breach notification, they are offering two years of credit monitoring and identity protection services to any individuals who may potentially have been affected by this cyberattack. Once they can identify impacted individuals, UGH agrees to make notifications and undertake related administrative requirements to help ease reporting obligations on affected parties.

In the meantime, individuals who are concerned that they may have been affected by this cyberattack can contact UHG's dedicated call center at **1-866-262-5342** to opt-in to free credit monitoring and identity protection services. The call center cannot provide any specifics on individual data impact at this time. Additional details can be found on UHG's dedicated website at http://changecybersupport.com/.

Once UGH identifies the impacted clients, individuals and data, we will provide you with an update, and we will work with UHG to provide appropriate notifications. In the meantime, Associated is offering to post the enclosed information for participants on the Fund's webpage.

If you would like for Associated to post the enclosed information on the Fund's webpage, please advise and we will do so promptly.

Sincerely,

Privacy Officer
Associated Administrators

AMENDMENT NO. ____1____

TO THE

ADMINISTRATIVE SERVICES AGREEMENT

This Amendment No. One (1) (the "***Amendment***") is effective April 1, 2024 (the "***Effective Date***") and amends that certain Administrative Services Agreement, dated as of April 1, 2020 [as subsequently amended] (the "***Agreement***"), by and between the Board of Trustees of the Carpenters Local No. 491 Health and Welfare Plan (the "***Fund***") and Associated Administrators, LLC ("***Associated***"). The Fund and Associated may sometimes hereafter be referred to individually as "Party" and collectively as the "Parties".

WHEREAS, Associated currently performs certain administration services on behalf of the Fund; and

WHEREAS, the Parties wish to continue the Agreement upon the same terms and conditions except as amended and stated in this Amendment, in an effort to ensure continuity of timely electronic claims payments due to the recent cybersecurity incident involving Change Healthcare and the need for an alternate solution.

NOW THEREFORE, in consideration of the foregoing premises, agreements set forth below, and for other good and valuable consideration, the receipt and adequacy of which are hereby acknowledged, the Parties agree as follows.

1. **Indirect Compensation.** Section EIGHTH of the Agreement is hereby amended as of the Effective Date to add the following subsection:

4. Associated shall not receive any indirect compensation from third parties related to the services it provides under the Agreement except as set forth below and in Schedule A attached hereto. Should Associated receive any additional indirect compensation during the Term of this Agreement, Associated shall disclose such compensation in compliance with applicable regulations.

a. Compensation for services under Section SEVENTH: Zelis Payments, Inc.
Associated will receive compensation for administration of the Electronic Claims Payments Services provided by Zelis Payments, Inc. to the Fund as set forth in Schedule A.

2. Electronic Claims Payment Services. A new Schedule A is hereby added, as of the Effective Date, as attached. Section SEVENTH to the Agreement is hereby amended to include the services outlined in Schedule A.

IN WITNESS WHEREOF, the undersigned have executed this Amendment No. 1 to the Agreement as of the Effective Date set forth above.

CARPENTERS LOCAL NO. 491 HEALTH AND WELFARE PLAN

_____
Trustee

Printed Name: _____

Date: _____

_____
Trustee

Printed Name: _____

Date: _____

ASSOCIATED ADMINISTRATORS, LLC

By: _____

Name: _____

Title: _____

Date: _____

SCHEDULE A

ELECTRONIC CLAIMS PAYMENT SERVICES

1. Associated Services.

a. Electronic Claims Payment Services. Through Zelis Payments, Inc. ("***Zelis***") as a subcontracted vendor, Associated will arrange for certain electronic payment functions (the "***Electronic Claims Payment Services***"), which includes the processing, consolidating and electronic payment on behalf of the Fund those health care claims administered by Associated and designated by the Fund to receive electronic payments. Electronic claims payments will not be made to: (i) any provider that has elected not to receive electronic payments or (ii) any provider contained in a payment file which is not an eligible provider.

b. Additional Administrative Services. In addition to arranging for the provision of the Electronic Claims Payment Services set forth above, Associated will provide the following additional services in support of the Electronic Claims Payment Services:

i. Associated will provide the following initial set-up services:

- Complete enrollment and set up Fund for Electronic Claims Payment Services.
- Establish relationship with Zelis and any third-party processors necessary to provide the Electronic Claims Payment Services.
- Implement, test and effect changes to the data file to and from Zelis.
- Build a connection from Zelis to the Fund's bank account.
- Update internal claims systems to accept feeds from Zelis.
- Update internal claims systems to show additional status and payment types associated with the new form of payment and reissued payments.
- Educate providers regarding implementation of the Electronic Claims Payment Services and offer assistance for implementation.
- Staff and train customer service staff on handling provider inquiries regarding Electronic Claims Payment Services, including providing information on the status of payments, reissuance of payments and changing payment types.
- Staff and train customer service staff for responding to questions from participants regarding Electronic Claims Payment Services.

ii. Associated will provide the following ongoing services in support of the Electronic Claims Payment Services:

- Ongoing reconciliation of electronic claims payments and provider claims
- Customer service to respond to inquiries from participants and providers
- IT support and follow-up if files are missing or delayed
- Ongoing reporting regarding utilization of the Electronic Claims Payment Services

2. Compliance.

a. Agreement to Comply with HIPAA Privacy Regulations. Associated has entered into a services agreement and a HIPAA business associate agreement with Zelis. Associated acknowledges that it remains responsible for the performance of the Electronic Claims Payment Services as the subcontractor of services, including Zelis' compliance with the terms of the business associate agreement.

b. Operating Rules Compliance. Zelis shall establish commercially reasonable procedures to enable Associated's compliance with the Council for Affordable Quality Healthcare ("***CAQH***") Committee on Operating Rules ("***CORE***") EFT & ERA Operating Rules promulgated by the Secretary of Health and Human Services addressing healthcare Electronic Funds Transfer ("***EFT***") and Electronic Remittance Advice ("***ERA***") transactions. Zelis is CORE certified and will provide the CORE Certification to Associated provided that; (i) Associated's payment system provides Zelis with any and all data and code sets necessary for Zelis to be CORE compliant with respect to Associated; and (ii) such payment system complies with the CORE Certification requirements.

3. Administrative Allowance. Within thirty (30) days after the end of each calendar month during the term of this Agreement, Zelis shall pay Associated an amount equal to the adjusted gross revenues that Zelis receives in connection with transactions involving the Fund for such calendar month multiplied by the Sharing Percentage (as listed below) applicable to such calendar month as an administrative allowance.

Sharing Percentage		
Processing Year 1	Processing Year 2	Processing Year 3 and thereafter
55%	55%	55%

4. Reporting. Upon request by the Fund, Associated shall provide reporting related to the Electronic Claims Payment Services. The Fund shall be permitted all rights and obligations to perform any audit or validation necessary to ensure that payments conform to acceptable standards as governed by Plan documents, fiduciary responsibility and other authorities promulgating such obligations unto the Fund.

CARPENTERS LOCAL NO. 491 VACATION BENEFIT
STATEMENT OF CHANGES IN FUND BALANCE - CASH BASIS
FOR THE THREE MONTHS ENDED MARCH 31, 2024

	January	February	March	Year To Date
Additions				
Employer Contributions	$ 34,910.40	$ 51,817.22	$ 65,491.75	$ 152,219.37
Interest Income	10.89	10.99	13.25	35.13
Total Additions	34,921.29	51,828.21	65,505.00	152,254.50
Deductions				
Audit Fees	-	-	-	-
Benefits Paid	-	-	-	-
Interest Paid	-	-	-	-
Legal Fees	-	-	-	-
Office Expenses	-	-	-	-
Postage	-	-	-	-
Printing	-	-	-	-
Bank Service Charges	-	-	-	-
Total Deductions	-	-	-	-
Net Increase (Decrease)	$ 34,921.29	$ 51,828.21	$ 65,505.00	$ 152,254.50
Fund Balance - December 31, 2023				217,078.88
Fund Balance - March 31, 2024				$ 369,333.38

Statement of Fund Balance - Cost Basis	
Cash - PNC - Vacation Payment	$ 335,199.59
Cash - BayVanguard	392,139.49
Other Liabilities	1,110.15
Accounts Payable - Stale Dated Checks	(359,115.85)
	$ 369,333.38